APPLICATION FOR NONRESIDENT IOWA PHARMACY LICENSE

Please type or print clearly in ink. Make changes as necessary.

1 APPLICATION FOR:

☐ Renewal ☐ New ☐ Address Chg. ☐ Name Chg. ☐ Ownership Chg. ☐ Pharmacist in Charge Chg.

FOR LICENSE PERIOD:

IOWA PHARMACY LICENSE NO.:

LICENSE FEE: **$150.00**

2 DBA, LEGAL NAME, & LOCATION OF PHARMACY:

Name _____

Address _____

_____

_____

City,State,Zip _____

Remit check or money order payable to:
IOWA BOARD OF PHARMACY EXAMINERS

3 PHARMACY PHONE (_____) _____ **FAX** (_____) _____

PHARMACY E-MAIL ADDRESS: _____

4 TYPE OF OWNERSHIP: ☐Individual ☐Partnership ☐Corporation ☐Other _____
(please specify)

5 Names, titles, and addresses of all principal owners, partners, and officers of the pharmacy.
Attach additional sheets if necessary.

_____

_____

_____

_____

PHARMACY EMPLOYEES: *(Use additional sheets as necessary.)*

PHARMACISTS *currently working at this location*.

6 *Pharmacist in Charge:*

NAME	LICENSE NO.	HRS WORKED/WEEK	SIGNATURE

7 *Staff Pharmacists:*

NAME	LICENSE NO.	AVG. HRS WORKED/WEEK

8 REGISTERED TECHNICIANS and PHARMACIST-INTERNS *currently working at this location.*

NAME	REGISTRATION NO.	AVG. HRS WORKED/WEEK

9 SUPPORTIVE PERSONNEL *currently working in the prescription department.*

(Non-pharmacists, non-technicians, or non-interns who may perform duties such as delivering or distributing, by any method, prescription drugs to patients located in Iowa. Do not include commercial delivery services or personnel.)

NAME	ADDRESS	AVG. HRS WORKED/WEEK

10 ATTACH COPIES OF THE FOLLOWING:

A) Copy of current license, permit, or registration certificate issued by the regulatory authority of the home state or territory (*home state*) OR letter from such authority certifying the pharmacy's compliance with the pharmacy and controlled substances laws of the home state.

B) Most recent inspection report resulting from an inspection conducted by the regulatory authority of the home state.

C) Evidence of correction of any noncompliance noted on inspection reports of the home state regulatory authority and all other regulatory agencies having authority over the pharmacy.

D) * Policies and procedures regarding the records to be maintained of controlled substances delivered, dispensed, or distributed to ultimate users in Iowa and detailing the format and location of those records. *

E) * Policies and procedures evidencing that the pharmacy provides toll-free telephone service to facilitate communication between ultimate users in Iowa and a pharmacist who has access to the ultimate user's records in the pharmacy. The policies and procedures shall include evidence that such pharmacist is available at least 6 days and at least 40 hours per week, and that the toll-free telephone number is printed on the label affixed to each prescription drug container delivered, dispensed, or distributed in Iowa. *

F) A prescription label including the toll-free number described in Item E above.

G) A complete, typewritten description of the type of pharmacy practice, i.e. retail, hospital, compounding, central fill, central processing, etc., including a description of the prescription drugs and services provided to patients in Iowa.

**** NOTE:*** *If the policies and procedures identified in Items D and E have not changed since previously submitted, a pharmacy completing this application for the purpose of changing or renewing a current Iowa pharmacy license may, in lieu of submitting duplicate copies of those policies and procedures, attach to this application a statement from the Pharmacist in Charge certifying that the policies and procedures on file with the Iowa Board of Pharmacy Examiners are current and unchanged.*

REMIT TO: IOWA BOARD OF PHARMACY EXAMINERS
400 S.W. EIGHTH STREET, SUITE E
DES MOINES, IA 50309-4688
PHONE: (515) 281-5944

Information provided on this application may be disclosed pursuant to 657 IAC Chapter 14.

I hereby swear under penalty of perjury that the information provided in this application is true and correct. I understand that failure to provide complete and truthful information may constitute grounds for denial, revocation, or other disciplinary sanctions against my license.

11 SIGN HERE

_____ _____ _____

Signature of Owner or Corporate Officer *Title* *Date*

INCOMPLETE APPLICATIONS WILL NOT BE ACCEPTED AND WILL BE RETURNED TO APPLICANT